SUMMARY NOTES

Maine Quality Forum Advisory Council
November 12, 2010

Present: Kathy Boulet, DC, Alex Dragatsi, Karynlee Harrington, Sue Henderson, Jeff Holmstrom, Frank Johnson, Robert Keller, Becky Martin, Al Prysunka, Doug Salvador, and Paul Tisher

Item	Discussion	Decision/Action	Date Due
Minutes of Meeting	Robert Keller noted that Summary Notes from the September 10, 2010 meeting failed to reflect the resignation of Josh Cutler. Given lack of a quorum, minutes will be revised and acted upon at the next meeting.	No action	
Resignation	Bob announced that Maureen Kenney resigned from the Advisory Council due to additional work related responsibilities. Nominations for her seat, representing large business, will proceed.	No action required	
Dirigo Health Agency Update	Karynlee Harrington reported that a new three-year contract recently was signed with Harvard Pilgrim Health Care to continue to serve as the insurance carrier for DirigoChoice. Despite future uncertainties, take-up in the small group market has been unusually high. Karynlee reported that the non-group base rate will not increase on January 1, 2011 despite average non-group commercial rate increases of 10-14 percent. DirigoChoice small group rates will have a 2 percent increase in the base rate compared to 7-24 percent in the general market. She noted that the DirigoChoice benefits are aligned with value-based purchasing (VBP) to the extent that there is no charge for preventive services, no deductible for pharmacy and mental health parity. A continued focus on VBP and linking payment more directly to quality of care is an ongoing goal of the program. Lastly, Karynlee reported that A nine-week schedule of radio ads is underway promoting the DHA's voucher program. Paul Tisher asked if the DirigoChoice program has evidence that mental health parity has reduced service use rates. Karynlee reported that a formal analysis has not yet been done. Current enrollment in Dirigo as of October 1, 2010 was 14,139. An enrollment goal of 22,000 is set for June, 2011. Sue Henderson underscored the importance of getting word out on the success of Dirigo. Karynlee indicated	Information only; no action required	

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	that members are coming forward with testimonials. She also noted that Dirigo has become part of the *Facebook* and *Linked-in* generation.		
Healthcare Associated Infections	Karynlee Harrington and Alex Dragatsi updated Council members on the HAI collaborative work. Per PL Chapter 346, all Maine hospitals are required to conduct surveillance for MRSA on high risk patients. A Resolve passed at the same time as the law which requires the MQF to work with others to develop a working definition of *high risk*. Alex reported findings of the MRSA prevalence study which reviewed the incidence of MRSA infections among patients at the time of admission to the hospital. There was discussion about how findings of the prevalence study should be reported to the Legislature, especially with respect to whether infection prevalence should be shown by hospital. Doug Salvador suggested that we should not report hospital-specific findings since incident rates reflect community-acquired infection control rather than the performance of individual hospital surveillance and treatment programs. Doug Salvador reported that as of January 2011, all Maine hospitals will report infection rates to the National Healthcare Safety Network (NHSN), a voluntary surveillance program for monitoring hospital-acquired infections. The MQF and Maine CDC are in discussions about how to access this data. The Maine Infection Prevention Collaborative has recommended that data submitted to the NHSN during the first six months be critically reviewed to assure standardization before it is publicly reported.	Information only; no action required	

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Patient Experience of Care	The Maine Health Management Coalition and Quality Counts support the work of the Agency in moving forward with the Patient Experience of Care survey work. The Clinician and Group Consumer Assessment of Health Care Providers and Systems (CG-CAHPS) is endorsed by the National Quality Forum as an effective tool to understand how well individual physicians and their practices are meeting the needs of patients. Members wishing to serve on a Steering Committee to oversee the initiative were asked to contact Alex or Karynlee.	For discussion Members interested in serving on Steering committee should contact Karynlee.	
Patient Centered Medical Home	Karynlee reported that Maine was one of eight states invited to participate in a federal Medicare demonstration. This award will pay a monthly fee for Medicare beneficiaries receiving care from the patient centered medical home (PCMH) pilot practices to provide enhanced care coordination services. In Maine, participation in the demonstration could bring in up to $24M additional dollars over the course of the three-year demonstration. A unique feature of Maine's participation will be the creation of community health teams (CHT) to work in concert with physicians to identify and support high-risk patients, facilitate self-care and transitions of care, and assist patients in connecting to community-based resources. To qualify for participation, Maine had to demonstrate budget neutrality. In making its "*budget neutrality*" estimates, the Dirigo Health Agency relied on data from it's *All-payer Analysis of Variation in HealthCare in Maine* to determine where savings could be achieved through better access to preventive and primary care services or through reduced use of unnecessary care that has no known impact on quality outcomes. Strong evidence suggested that a 10 percent reduction in hospitalizations and emergency room visits among Medicare beneficiaries would be possible by focusing on areas that could be avoided through prevention and more timely access to effective primary care (e.g., dehydration, urinary infections, congestive heart failure, hypertension, asthma,	Information only	

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	chronic obstructive pulmonary disease, uncontrolled diabetes.		
MONAHRQ	Karynlee discussed her meetings with the National Quality Forum which is providing guidance to federal DHHS on a Quality Strategy. Part of that strategy is the development of a national dashboard to compare data across the country in key domains. To help standardize the reporting and display of quality data, the Agency for Healthcare Research and Quality (AHRQ) developed MONAHRQ, software that analyzes, summarizes, and presents information on: quality of care at the hospital level**,** health care utilization at the hospital level, preventable hospitalizations at the county level, and rates of conditions and procedures at the county level. Discussions with the NQF raise many questions about MQF's own quality strategy, especially with respect to the reporting of its data. This strategy must be developed within the context of many other Maine organizations whose missions include the collection, use and reporting of health care quality data, such as the Maine Health Management Coalition and HealthInfoNet. Health reform and the development of accountable care organizations within the State places increased urgency on designing strategies that provide real-time quality data to providers and payors.	Information only	
National Health Reform Steering Committee	Karynlee reported that the Steering Committee has been meeting for over six months to review provisions and implications of the Affordable Care Act in Maine. A report on this analysis with options for consideration by the next administration will be presented at a Public Hearing on December 14, 2010. The Governor's Office of Health Policy and Finance was recently awarded $1M as a planning grant for the design of healthcare exchange in Maine.		
Recruitment of MQF Director	Karynlee solicited ideas from the Council on desired qualifications for the next director. Specifically she questioned whether the next MQF Director must be a physician as has been the case in the past. Frank Johnson suggested that, although early in its development the MQF benefitted from the clinical credibility of its director, it may not be a pre-requisite going forward. Management skills were seen as a higher priority within the organization at		

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	present. Sue Henderson noted that a physician director helps bring the practice community together on initiatives that can otherwise be quite controversial. Generally members felt that it will always be important to have the medical perspective represented in the organization but that others may also be well suited for the director position.		
Next Meeting	The next meeting of the MQF Advisory Council is scheduled for Friday, February 11, 2011.		